Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: IRVING COPPELL SURGICAL HOSPITAL 400 W. I-635 IRVING, TX 75063-1158	MFDR Tracking #: M4-09-A294-01
Respondent Name and Box #: NEW HAMPSHIRE INSURANCE REP. BOX #: 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on the Table of Disputed Services: "Appeal faxed 06/03/09, confirmation received, no response from the carrier. No paid according to MAR."

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill
3. EOB
4. Medical Reports
5. Total Amount Sought $7,312.45

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary as stated on the Table of Disputed Services: "Per review additional allowance not recommended."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
02/10/2009	Hospital Outpatient Services	$9,299.48 (APC) +$0.00 (Outlier Amount) = $9,299.48(OPPS) x 200% + $42.15 (Fee Schedule) = $18,641.11 (MAR) - $11,296.79 (Total paid by Respondent) = $7,344.32. Requestor is seeking $7,312.45	$7,312.45	$7,312.45
			Total Due:	$7,312.45

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided in an outpatient acute care hospital on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 04/07/2009:
   - 59 – Process based on multiple or concurrent procedure rules.
   - 97 – Payment is included in the allowance for another service/procedure.
   - W1 – Workers Compensation state fee schedule adjustment.
   - 18 – Payment adjusted because this procedure code was invalid on the date of service.
   - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymnt requests, submit a copy of the EOR or clear notation tha.
   - BL = Section 413.042 of the Texas Labor Code prohibits a provider from balance billing an injured worker for workers' compensation.

   Explanation of benefits with the listed date of audit 07/20/2009 (after Requestor's submission to MFDR):
   - DL – This bill is a reconsideration of a previously reviewed bill.
   - BL – Additional allowance is not recommended as this claim was paid in accordance with state guidelines, usual/customary policies, or the providers PPO contract..
   - BL – To avoid duplicate bill denial. For all recon/adjustments/additional pymnt requests, submit a copy of the EOR or clear notation that a recon is requested.
   - BL – (197) – Precertification/authorization/notification absent.
   - 19 – (197) – This line was included in the reconsideration of this previously reviewed bill.
2. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or

   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;"
3. Pursuant to Rule §134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Within each APC, payment for ancillary and supportive items and services is packaged into payment for the primary independent service. Separate payments are not made for a packaged service, which is considered an integral part of another service that is paid under OPPS. An OPPS payment status indicator is assigned to every HCPCS code. Status codes are proposed and finalized by Medicare periodically. The status indicator for each HCPCS codes is shown in OPPS Addendum B which is publicly available through the Centers for Medicare and Medicaid services. A full list of status indicators and their definitions is published in Addendum D1 of the OPPS proposed and final rules each year which is also publicly available through the Centers for Medicare and Medicaid services.
5. Upon review of the documentation submitted by the Requestor and Respondent, the Division finds that:

   (1) No contract exists;

(2) MAR can be established for these services; and

(3) Separate reimbursement for implantables was *NOT* requested by the requestor.

(4) According to Division Rule at Texas Administrative Code 134.403, REV code 360 (CPT Codes 35207-F8, 64831-F8, 64779-F8, 14040-F8, 26350-F8 and 64832-F8) has a status code indicator of T which means that outpatient significant procedures subject to multiple procedure discounting. The highest paying state T APC is paid at 100%; all others are paid at 50%. REV code 300 (CPT codes 36415, 80047, 85014, and 81002) has a status code indicator of A which means these codes are paid under a Fee Schedule or with a Prospectively Pre-Determined Rate. REV code 320 (CPT Code 73140-RT-TC) has a status code indicator of X which means that this code is consideration ancillary services, paid as APCs rather than from a Fee Schedule.

6. Consequently, reimbursement will be calculated in accordance with Rule §134.403 (f)(1)(A) a follows:

APC	Outlier Amount	Separate Reimbursement for implantables WAS NOT requested under Rule §134.403	APC + Outlier Amount X 200%	Fee Schedule (CMS + DWC conversion factor)	Subtract Amount Paid by Respondent	Results in additional Amt Due to Requestor
$9,299.48	$0.00	$0.00	$18,598.96	$42.15	$11,296.79	$7,312.45 According to Requestor's Table of Disputed Services

Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor is due additional payment. As a result, the amount ordered is $7,312.45.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. 413.011(a-d), 413.031 and 413.0311
28 TAC Rule §134.403
28 TAC Rule §133.305
28 TAC Rule §133.307

PART VII: DIVISION DECISION

The Division hereby ORDERS the respondent to remit to the requestor the amount of $7,344.32 plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.